UNDERSTANDING FLEXIBLE BENEFITS

Flexible Benefits started when Congress passed Section 125 of the Internal Revenue Code in 1978. Section 125 allows certain qualified expenses, estimated for a given year, to be deducted directly from your paycheck and claimed for reimbursement when used. These deductions are taken before taxes, therefore, reducing your taxable income.

Example: Mary is single with three children and Mary earns $3,000 per month. She pays $125 a month in childcare expenses and $25 a month for prescriptions. The calculations below show how much Mary will save by participating in the Flexible Benefit Plan her company offers.

WITH FLEXIBLE BENEFITS		WITHOUT FLEXIBLE BENEFITS	
$3,000.00	Income	$3,000.00	Income
-150.00	Expenses	-332.00	Federal Tax
$2,850.00	Taxable Income	-90.00	State Tax
-295.00	Federal Tax	-229.50	SocSec/Medicare
-85.55	State Tax	$2,348.50	Net Income
-218.02	SocSec/Medicare	-150.00	Expenses
$2,251.43	Mary's Income	$2,198.50	Mary's Income

****MARY WILL SAVE $52.94 EACH MONTH AND $635.15 A YEAR BY PARTICIPATING****

DEPENDENT CARE REIMBURSEMENT

Dependent Care Reimbursement enables you to deduct childcare (day care) or elder care expenses up to $5,000 a year per family or $2,500 if married filing separate, before taxes. A claim is then filed to receive reimbursement for the expense(s). **Eligible Expenses include** charges for before and after school programs, babysitting, day care, summer camps, and elder care.

The following rules apply:

- You must substantiate the expense with a receipt showing the date(s) of service, amount charged, and the provider's name and federal identification or social security number.
- A dependent must be under age 13 or disabled at any age.
- The service(s) must be provided while you and your spouse work, or attend school full-time.
- Expenses cannot exceed the lower income of either spouse.
- If using a day care center, it must be licensed.
- Baby-sitting services provided by a dependent relative under the age 19 are not eligible.
- Overnight camps are not eligible.

HEALTH CARE REIMBURSEMENT

Health Care Reimbursement enables you to deduct medical, dental, and vision expenses up to the maximum annual amount set by your employer, before taxes. A claim is then filed to receive reimbursements for the expense(s). **Eligible Expenses include** (but are not limited to) charges for medical, dental, or vision office visits, prescription drugs, over-the-counter drugs purchased to treat a medical condition,**(see updated restrictions effective 01/01/11)**, x-rays, labs, orthodontia, teeth cleanings, bridges, crowns, eye exams, glasses, contacts, lasik eye surgery, ambulance and emergency room fees, diabetic supplies, dust-free products, alcohol and drug treatment centers, smoking cessation programs, and weight loss programs for obesity.

The following are some (but not all) items that are not eligible:

- Bleaching/whitening of teeth
- Cosmetic procedures/surgery
- Exercise equipment
- Vitamins

PROCEDURES & SERVICES

- All expenses need to be estimated for the Plan Year. Please be conservative when estimating. Any funds left in the account will be forfeited at the end of the grace period for the Plan Year.
- At the beginning of each new Plan Year, you will be given the opportunity to elect if you would like to participate.
- Your election cannot be changed mid-plan year unless there is a change in your family status that is a qualifying event. The following are qualified events: marriage, divorce, birth or adoption, death, or a change in you or your spouse's employment. All changes must be consistent with your new election choice and must be made within 30 days of the qualifying event. To discuss a specific event, please contact Customer Service.
- As the contribution you elected is deducted from each of your paychecks it is recorded in your Health Care and/or Dependent Care Reimbursement Account(s).
- To receive the funds from these accounts, you must complete a on line claim form then print and fax the claim form along with documentation showing the type of service provided, amount you are responsible to pay, and date(s) of service(s).
- All claims must be for services incurred during your coverage period of the Plan Year. Incurred is defined as the date in which services are provided. Coverage period is defined as the first of the month in which your first contribution is deducted and the last day of the month in which your last contribution is deducted.
- In the event you terminate employment, the end of the month in which you last contributed to the Plan becomes your termination date. Services performed after your termination date are not eligible for reimbursement.
- Once the claim is reviewed and approved, a reimbursement will be sent directly to your home address. Claims received by 5:00 p.m. Eastern Time on Mondays are payable the following Wednesday. Claims received by 5:00 p.m. Eastern Time on Wednesdays are payable the following Friday.
- Be sure to notify Customer Service of a change in address by updating it on your claim form or completing and sending in an employee change form.
- Access to your account information is available to you 24 hours a day, 7 days a week on the Internet at www.sheakley.com/flex.asp.To access your account, follow the site to "Participant Center" and click on "MyRSC Login". Registration instructions are included at the end of this packet. The website information is updated daily. A statement will also be posted to your online account 60 days prior to the end of the Plan Year reminding you of any remaining funds in your account and the deadline to submit claims.
- For specific information regarding your plan, the grace period, health care annual limit, plan year, and more, please refer to your Summary Plan Description or contact Customer Service.

CUSTOMER SERVICE

Customer Service representatives are available to assist you from 8:00 a.m. to 5:00p.m. Eastern Time Monday through Friday, except on holidays. Customer Service can assist you with determining if a certain expense is eligible for reimbursement, if a certain change in your family status is considered a qualifying event, and much more.

Sheakley / Flexible Benefits Division
One Sheakley Way/Cincinnati, OH 45246
Phone: (800) 877-6630 or (513) 326-4662
Fax: (513) 326-8082
Email: 125@sheakley.com
www.sheakley.com

ELIGIBLE & NON-ELIGIBLE EXPENSES

To validate the expenses you will need to submit documentation that clearly shows the type of service, date of service, and the amount you are responsible to pay, along with a completed claim form. For over-the-counter items, a cash register receipt with the product name listed is required.

The following lists are expenses that will be covered and expenses that will not be covered.

COVERED ITEMS

- Acupuncture
- *Air Filters
- Alcoholism/Drug Abuse treatment
- Braille books/magazines
- *Breast Reduction/Reconstruction
- Car hand controls
- Childbirth classes
- Chiropractic
- Christian Science Practitioners
- Coinsurance amounts
- Contact Lenses & solutions
- Co-payments
- Crutches
- Deductibles
- Dental treatments
- Eyeglasses
- Fertility treatments
- Foreign Country medical expenses
- Guide dogs/expenses
- Hearing Aids
- Hospital co-pays/expenses
- Human Guide expenses
- *Impotence Treatment
- Laboratory fees
- Lasik Eye Surgery
- *Massage
- *Mattresses
- *Mileage for Medical Travel
- *Nursing Home Care
- Office visit co-pays
- Optometrist fees
- Orthodontia
- Orthopedic shoes
- Osteopathic expenses
- *Over-the-counter items **(see below)**
- Prescription medications
- PRK/Lasik
- Psychologist fees
- Radial Keratotomy
- Smoking Cessation programs
- Sterilization
- Sunglasses (prescriptions)
- Vision Care
- *Weight Loss programs
- Wheelchair equipment/expenses

This is not a complete list. If you have any questions regarding a specific type of expense that is not listed, or questions about items that are listed, please contact Sheakley Flexible Benefits Division toll-free at 800-877-6630 or e-mail to 125@sheakley.com.

Items marked with an * are only eligible if they are submitted with a written prescription from a medical doctor (MD) stating they are medically necessary and being used to treat a specific medical condition.

OVER-THE-COUNTER MEDICINES

*****Effective 01/01/2011, the Following Over-The-Counter Medicines Require a Prescription from a Doctor*****

- Allergy medicine Sunburn relief and sunscreens
- Antacids
- Anti-diarrhea medicine
- Aspirin
- Bactine
- Ben Gay or products for muscle or joint pain
- Bug bite medications
- Calamine lotion
- Cold medicine
- Cough drops
- Cough syrups
- Diaper rash ointment
- First aid cream
- Heartburn medicines
- Hemorrhoidal cream
- Hydrogen Peroxide
- Heartburn/Acid Reflux/Antacids
- Laxatives
- Liquid adhesive for small cuts
- Medicated shampoo
- Medicated soap
- Lactose Intolerance Medicines
- Laxatives
- Menstrual Pain Medication
- Motion Sickness Medication
- Motion sickness pills
- Nasal sinus sprays
- Pain relievers
- Pedialyte
- Rubbing alcohol
- Sinus medications
- Sleeping aids for occasional insomnia
- Spermicidal foam
- Sunburn relief
- Suppositories
- Wart Removal Medications
- Weight Loss Drugs
- Wrist/Ankle/Knee Supports
- Vitamins
- Visine or other eye products
- Yeast infection treatments

This is not a complete list. If you have any questions regarding a specific type of expense that is not listed, or questions about items that are listed, please contact Sheakley Flexible Benefits Division toll-free at 800-877-6630 or e-mail to 125@sheakley.com.

OVER-THE-COUNTER ITEMS

*****The following over the counter items are not considered medicine, therefore a prescription from a doctor is not required*****

Bandages
Blood pressure kit
Carpal tunnel wrist supports
Cold/hot packs for injuries
Condoms
Contact lens solution
Diabetic Insulin
First aid kits
Gauze pads
Incontinence supplies
Nasal strips
Nicotine gum or patches
Ovulation kit
Reading glasses
Denture Adhesive Products
Thermometers

This is not a complete list. If you have any questions regarding a specific type of expense that is not listed, or questions about items that are listed, please contact Sheakley Flexible Benefits Division toll-free at 800-877-6630 or e-mail to 125@sheakley.com.

ITEMS THAT ARE NOT COVERED

*****The following items are not considered to be medically necessary, therefore not reimbursable under the FSA plan.*****

Bleaching of teeth
Cosmetic Item
Cosmetic Surgery
Dietary Supplements
Moisturizers
Tooth Brushes (including electric)
Drugs not approved in the US
Whitening of teeth
Medicated Soaps Shampoos
Toiletries
Mouthwash
Weight Loss Food
Chapstick
Deodorant
Face Creams
Toothpaste

This is not a complete list. If you have any questions regarding a specific type of expense that is not listed, or questions about items that are listed, please contact Sheakley Flexible Benefits Division toll-free at 800-877-6630 or e-mail to 125@sheakley.com.

How Reimbursements Work:

1. **Reimbursements are Based on Service, Not Payment:**

   A big misconception is that if you pay for a service, then you are eligible for reimbursement. This is not true. Once a service is performed, regardless if payment has been made, you become eligible for reimbursement. There are pro's and con's to this rule.

   PRO – Once services have been rendered; just send in the bill and Sheakley will send you reimbursement.

   CON – Prepayment for services are ineligible for reimbursement until the service has taken place.

   Please remember with regards to the above, the services must have been incurred while you had coverage. Additionally, the service would need to be for a plan year that is currently active.

2. **Providing the Correct Documentation to Ensure Speedy Reimbursements:**

   In addition to filling out your claim form on line, you need to provide third party documentation (canceled checks, credit card receipts, and credit card or bank statements are not considered proper documentation). Third Party Documentation means documentation from the provider, or an Explanation of Benefits from your insurance. This documentation MUST include three things:

   1. The Date of Service. (Not the date of payment)

   2. The Type of Service. (Service performed)

   3. The Amount you are responsible to pay. (Remember again with this, it does not matter if the service has been paid.)

Deadline for incurring services

In May 2005, the IRS ruled to allow more time for participants to incur expenses each year and reduce the chance for forfeitures. Your employer has elected to modify the flex plan to include this option. Workers who are unable to spend their funds prior to the end of the plan year, now have an extra 2 1/2 months, after plan year-end, to incur eligible expenses before being forced to forfeit unused funds. It is essential to understand that the use-it-or-lose-it rule still exists, but the extension greatly softens the blow by allowing you more time to use your unspent FSA balances. How it works: Let's say you miscalculate and wind up with a leftover FSA balance of $500 on December 31, 2014. Under the new IRS guidelines, you have until March 15, 2015 to incur enough qualified expenses to use your $500 balance. The 90 day grace period deadline will still end March 31st to turn in any expenses you want applied to the 2014 plan year.

Please be advised that claims submitted within the 90 day grace period, which were incurred in the first 2 ½ months following the end of the plan year, will be applied as follows:

- Any unused funds from 2014 will be applied first for reimbursement of the claim.
- Any 2015 funds will be applied to the claim, if the requested amount exceeds your leftover 2014 balance.

This gives you 14 1/2 months to recover 2014 FSA contributions and provides a much-needed margin for error when figuring out how much to contribute to your FSA each year.

Note: The 2 ½ month extension does not apply to terminated employees, or participants who terminate their coverage during the plan year due to a qualified event.

Dependent Care (What it is and how it Works)

Dependent Care allows participants to set aside pre-tax funds from their paycheck to pay for daycare and eldercare services. There are a few misconceptions on how this plan works, and how a participant is reimbursed for these expenses.

The Dependent Care Plan is for daycare expenses for children and certain care expenses for disabled dependents and elderly parents. (We recommend you consult a tax consultant regarding your eligibility for claiming disabled dependents or elderly parents.)

1. **Day Care Expenses**. There are specific rules and regulations when it comes to reimbursement for day care services. Day care expenses are covered until the child reaches the age of 13. Once the child reaches the age of 13, they are no longer eligible and the participant MUST cease participating in this plan.

2. **Tuitions.** Tuition for **Pre-School IS COVERED**, as the government does not consider Pre-School to be educational. Since this plan is designed for care, and not education, once a child enters Kindergarten the only expenses that are reimbursable are before and after school programs that the child attends so that both parents may work, or attend school.

3. **Babysitters.** These providers generally care for children of the employee in the employee's home and are not usually regulated. They can be grandparents or other relatives, friends, or neighbors. However, payments are not reimbursable if the babysitter is the employee's child or stepchild who is under age 19, or if the babysitter is a dependent for whom the employee or spouse can claim an exemption on Form 1040. **The social security number of the provider is required for reimbursement.**

4. **Camps.**

   Summer Day-camp: Yes, to the extent attributable to care of dependent regardless of whether the program includes instruction for sports or other extracurricular activities. The primary purpose of the expense for summer day-camp should be custodial in nature and not educational.

Over-Night camp: Since the Dependent Care plan was designed to assist in care while parents are at work, over-night camps are **NOT COVERED** under this plan.

5. **Custodial or elder care expense.** Only if (a) such expenses are not attributable to medical services; and (b) the qualifying individual (other than a dependent under age 13) still spends at least eight hours each day in the employee's household.

6. **Food expenses.** No, if charged separately from dependent care expense. May be eligible if inseparably part of dependent care charge. In other words, if the food is included in the price of the dependent care, then It can be covered if the cost of the food is separate from the cost of the dependent care, then it will not be covered under this plan.

How Am I Reimbursed for Dependent Care Expenses?

Similar to the Healthcare plan, reimbursements are based on date of service rather than date of payment. In other words, a plan may not reimburse a claim in August for the participant's advance payment of a child care center's bill for care to be provided in September. Although the participant paid the child care bill in August, the expense is not "incurred" until the services (child care) are actually provided. The plan may not reimburse the participant for the expense until October, after all of the September services have been provided.

Good News Regarding Payment*

With Sheakley's new Dependent Care claim form, the monthly expense can be broken down on a weekly basis; this means that if you paid $500.00 for the month of August, with the new claim form, you can break it up into weekly amounts so that at the end of each week, a portion of your claim is substantiated and if there are funds in your account, you will be reimbursed. Please be sure you use the most up- to-date claim form.

HEALTH CARE WORKSHEET

This worksheet will help you estimate your family's annual expenses for the new Plan Year. Please remember to deduct what your insurance will pay on each item. Not all covered expenses are listed; this is a list of the most common expenses. If you are not sure if an expense is eligible, please contact Customer Service via email at 125@sheakley.com.

****NOTE TO HSA OWNERS:** If you are the owner of a Health Savings Account, refer to the plan information to determine your FSAeligibility and eligible expenses. If you are eligible to participant in the Flexible Spending Account, please note that **only dental and vision expenses can be reimbursed.**

Medical Expenses	Current Year's Expenses	Estimate for Next Year
Deductible	$_____	$_____
Co-Payments: Office	$_____	$_____
Prescriptions	$_____	$_____
*Over the Counter Items	$_____	$_____
Chiropractors	$_____	$_____
Hospital Care	$_____	$_____
Physical Therapy	$_____	$_____
Routine Physcial	$_____	$_____
Well Baby Care	$_____	$_____
Psychiatric Care	$_____	$_____
Other	$_____	$_____
Vision Expenses		
Eye Glasses	$_____	$_____
Eye Exams	$_____	$_____
Contact Lens	$_____	$_____
Lasik/Vision Correction	$_____	$_____
Dental Expenses		
Dental Exams	$_____	$_____
Extractions	$_____	$_____
Fillings	$_____	$_____
Crowns	$_____	$_____
Bridges	$_____	$_____
Orthodontics	$_____	$_____
X-Rays	$_____	$_____
Other	$_____	$_____

Total Estimated Expenses: $_____ **Number of paychecks in the plan year:** _____

Divide to show per paycheck pre-tax deduction: $_____

Check your numbers carefully and remember to be conservative. Any funds left in the account are forfeited. Only estimate expenses you know you or your dependents will have completed.

DEPENDENT CARE WORKSHEET

This worksheet will help you estimate your family's annual expenses for the new Plan Year. If you are not sure if an expense is eligible, please contact Customer Service via email at 125@sheakley.com.

1.	Day Care Expenses	$_____/week x 52 weeks =	$_____
2.	Estimated time away from the day care or sitter (vacations or holidays)	$_____/week x # weeks =	$_____
3.	Subtotal	_____ #1minus #2 =	$_____

Does your child start school this year? If so calculate only the full months that he/she is not in school and partial daycare for the remainder of the Plan Year.

_____

4.	Estimated change in expenses (day care increases or decreases in the amount)	$_____	
5.	Estimated Yearly Day Care Total	#3 plus/minus #4 =	$_____
		Divided by number of paycheck dates =	$_____

REMEMBER TO BE CONSERVATIVE: any funds left in this account will be forfeited.

ENROLLMENT FORM

SECTION 1: Participant Data

Please legibly complete the following information to set up your account.

Employee Name (First/Last)			Social Security #	
Home Address		City	State	Zip Code
Hire Date	Birth Date	Email Address		
Employer: City of Torrance				

SECTION 2: Elections

Enter the amount you wish to contribute per pay period, the number of paychecks you will receive during the entire plan year, multiply the per pay by the number of paychecks for the annual election, and enter the first paycheck date in which a deduction will be withheld.

Plan Year: 1/1/2014-12/31/2014	Per Pay Contribution	# of Paychecks Remaining	Annual Election	Effective Paycheck Date
Health Care Reimbursement (Annual Limit $ 2,500.00)	$	#	$	
Dependent Care Reimbursement (Annual Limit $5,000.00 per household or $2,500.00 if married filing separate)	**$**	#	**$**	

SECTION 3: Pre-Taxed Premiums

I understand my insurance premiums, offered by my employer only, will be deducted on a pre-tax basis unless I note otherwise, in writing, to my Human Resources Office.

SECTION 4: Plan Information

Please read the following information regarding this enrollment. If you do not wish to participate in the Flexible Benefit Accounts, sign the declination line. If you wish to enroll into the Flexible Benefit Plan, sign the participation line.

I wish to participate and deposit to the Flexible Spending Account (FSA) as shown above. I understand that my election may not be terminated or changed unless I have a qualified life event as outlined by the IRS. I understand that all claims must be for services provided (not paid) during my coverage period. I further understand that the IRS requires a forfeiture of any remaining balance in my account, as of the last day of the grace period in which I am allowed to submit claims. I understand that upon termination of my coverage (due to a qualified life event or termination of employment) I cannot continue to incur additional expenses; I may only submit claims for services performed prior to my termination date. Upon termination of my Healthcare Reimbursement Account, I may be able to elect COBRA to continue my coverage. In order to receive reimbursement from this account, I must complete and sign a claim form and attach all necessary documentation for myself or my dependents. I understand the plan provisions have been outlined in the Summary Plan Description available to me from my employer.

In addition, I understand that if I have a Health Savings Account (HSA), it is my responsibility to review the FSA plan information to make sure that I am able to participate in both the HSA and the FSA. If my plan allows for participation in both a FSA and a HSA plan, I understand that I can only submit dental and vision expenses toward my FSA account.

PARTICIPATION SIGNATURE: _____ DATE:_____

WAIVER: **At this time I wish to waive participation in the Flexible Benefit Account.**

DECLINATION SIGNATURE: _____ DATE:_____

All Enrollment forms must be submitted to your HR Department for processing.

EMPLOYER SIGNATURE: _____ DATE:_____

To: Flexible Benefits Participants

Below are instructions to log into the new online Flexible Benefits Plan account inquiry. This new online feature is a password protected web site, where you can keep up with various benefit news, including your year-to-date claims and payments. To log in to *my*RSC for the first time, follow the steps below:

1. Go to http://www.sheakley.com/flex-participant.asp
2. Click on MyRSC Login
3. Click on Register
4. Enter your social security number (no dashes or spaces) in the Login ID field and click continue
5. Enter 25950569 in the Employer Code Field
6. Enter a Login ID of your choice that is at least 6 characters but no more than 100 characters. Note: Since your social security number is used for the temporary code, the Login ID that you create cannot be 9 characters long.
7. Select an existing e-mail address or enter a new one to be used to e-mail forgotten passwords.
8. Enter a secret questions or use a predefined secret question to prompt your memory of your password.
9. Enter the answer to the secret question.
10. Click **SUBMIT**.
11. Click the continue link.
12. Enter a password in the password field.
13. Re-enter the password in the Confirm Password field.
14. You are no logged into MyRSC.

If you have any questions, please call our
Customer Service Department at
1-800-877-5055

EMPLOYEE PERSONAL DATA CHANGE FORM

Please complete and sign this form. Give to your Human Resources Department who will forward to Sheakley via fax to (513) 326-8082.

_____ _____ - _____ - _____
Employee Name Social Security #

_____ _____/_____/_____
Company Name Effective Date of change

CHANGE IN NAME

_____ _____
Old Name New Name

CHANGE IN ADDRESS

_____ _____
New Street Address/P.O. Box New City

_____
New State & Zip Code

SIGNATURE REQUIRED

_____ _____
Signature **Date**

MySourceCard Enrollment Agreement

As a participant in one or more of your Employer Plans or as an account holder under HSAtoday program, you will receive a MySourceCard MasterCard Debit Card issued by Benefit Bank, and agree to use it according to this Agreement and the Cardholder Agreement that will be provided to you with the Card.

You understand that the Card is restricted to certain merchant categories and is not accepted at all MasterCard acceptance locations. You understand that you may not obtain a cash advance with the Card at any merchant, bank, or ATM. You understand that the Card is to be used *exclusively* for Qualified Expenses as defined by the plan(s) in which you participant. If the Card is issued pursuant to Employer Plans and you use the Card for an expense that is not a Qualified Expense, you are indebted to your employer and must repay the full amount of the non-qualified expense.

You agree to save all invoices and receipts related to any expense paid with the Card; upon request you must submit these documents for review by the Plan Service Provider. Failure to submit the receipt(s) will cause the expense to be treated as a non-qualified expense and you will be required to remit payment to your employer. Payment may be in the form of an offsetting claim, a personal check, electronic draft from your personal checking or savings account, a post-tax deduction from your paycheck, or other options established by your employer.

Please Note: Additional terms and conditions would apply if you use the Card to access your funds in your HSA under the HSAtoday program. In such event, these additional terms and conditions would be set forth in an HSA Addendum to your HAS custodial account agreement.

For proper Cardholder Identification, please complete the following information.
Your Card will not be issued until this form is received by your Plan Service Provider.

Employer: _____

Name on Card: (Please Print)_____

Address:_____ City:_____ State:_____ Zip:_____

Social Security Number:_____ Date of Birth:_____ Work Phone:_____

E-Mail Address: (Required) _____
**E-Mails regarding any card transactions will go to the E-Mail provided.

Mother's Maiden Name: _____

Signature:_____ Date:_____

ALL FIELDS ARE REQUIRED

For Office Use Only

Requested (Initials)_____ Date:_____

INFORMATION REGARDING THE FLEXIBLE BENEFIT DEBIT CARD

The card can be used to pay for any expenses/procedures that are medically necessary, Dependant Care (day care) and Parking and or Transportation (if your company has these plans). Please be advised, the cards were not implemented by the government to eliminate sending in documentation if requested but rather, to allow participants to pay for services without having the funds in their pocket and then sending in a request to be reimbursed. We have tried our best to lower the amount of transactions in which back up is requested.

This is based on 2 things:

1. If the amount of the transaction matches any co pay amounts provided by your company, the transaction will auto substantiate.

2. If the provider where the card is being used has the updated software, recommended by the IRS, to read the item as an eligible flex item, the transaction will auto substantiate.

When someone uses the card, it sends information on *where* the card was used and *the amount* that was used. It does not tell us what the service/purchase was for. ** Please do not assume that simply because the card was used at a doctor's office, that back- up won't be requested, as not all services provided by a doctor are covered under the FSA plan.**

With this plan, it is the participant's responsibility to show the IRS that the item/service was an eligible expense. IN order to determine the expense is an eligible expense, we need to know the type of service.

Please keep in mind, when you are having a service done or purchasing an item, it is being done with tax free dollars and there are rules/procedures that the IRS requires.

Below is a breakdown of how the card works:

Each time you swipe your card, you will get an initial email just confirming you swiped your card. It will say that you will be notified if additional info is needed.

The second email you get is going to say one of two things:

1. Either that you swiped your card and the claim is fully substantiated and no action is required. If you get this one, then you don't have to do anything.

2. If the second email says the transaction **"Needs Attention"** that means the amount of the swipe falls outside the parameters for you company. What you will need do is print the e mail and fax it along with the backup (the receipt showing the amount of the service, the type of the service, and the date of the service) to the fax number listed on the email **(YOU DO NOT FILL OUT A FORM)**.

If backup is not received within 21 days, the card may be temporarily blocked until the backup documentation is received by Sheakley's office. Any claim forms received while a card is in blocked will be applied to the debit card transaction amount before reimbursement is issued.

The only time you will need to complete an online claim form is if you pay for something out of pocket and we need to reimburse you the money.